

Electronic Data Interchange (EDI)

- ❑ Supervisor must file claims Electronically with EDI within 2 working day of employee notice
- ❑ Filing Claims Electronically
<https://extranet.apps.cpms.osd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20Unemployment%20Compensation%20Branch/Online%20Tools%20Overview/DIUCS%20Supervisor%20Link.aspx>
- ❑ Supervisor should call or email ICPA regarding notification on electronic posting
- ❑ Supervisor should forward any Medical Documentation received from employee to

Electronic Data Interchange (EDI)

- ☐ It has been DoD policy since July 2003 to utilize EDI when submitting claims
- ☐ DOL will be monitoring agency timeliness for claim submission as a result of SHARE
- ☐ Defense Safety Oversight Council (DSOC) will be monitoring DoD agency timeliness and use of EDI for claim

Electronic Data Interchange (EDI)

- ☐ Claims filed utilizing EDI are electronically transmitted to OWCP from the agency
- ☐ Any delay due to internal routing of paper claims and mailing forms to OWCP are eliminated

CLAIM PROCESS

- ❑ Employee reports the injury to his/her supervisor
- ❑ Process is started by accessing the EDI website
- ❑ Supervisor and employee complete the electronic form, which is transmitted to the ICPA. Supervisors do not need any special access to file the claim electronically, only a computer with internet access

CLAIM PROCESS

- ❑ ICPA receives an email notification of the supervisor's claim submission
- ❑ ICPA will receive, via email, a copy of the OSHA 301 to forward to the appropriate Safety Office if that Safety Office does not have an established alias

CLAIM PROCESS

- ❑ ICPA “authenticates” the form (i.e. verifies employment status, enters appropriate codes, corrects any errors); form is then transmitted to DOL
- ❑ If there are no problems with the claim, the ICPA will receive an email with the case number within 2-3 business days
- ❑ If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection

CLAIM PROCESS

- ❑ If there are problems with the claim then the ICPA will receive an email notification of the claim rejection and the reason for the rejection
- ❑ The EDI forms are patterned directly on the hard copy forms CA-1 and CA-2. Therefore, the basic instructions for completing the forms are the same as with paper

DIUCS: Supervisor Link - Windows Internet Explorer

https://extranet.apps.cpmosd.mil/Divisions/Benefits%20and%20Worklife/Injury%20and%20U...

File Edit View Favorites Tools Help

Favorites ACPOL-CPOL Homepage ... Army Knowledge Online ASAP IPR CHRA AKO CPMS-CARE Home Page ... CPOL Portal 8.1 Desktop

DIUCS: Supervisor Link

Page Safety Tools

DEPARTMENT OF DEFENSE
DCPAS
Defense Civilian Personnel Advisory Service

"Innovate & Lead"

Newsletters

Everything

Home HR Professionals Civilians Leaders Training & Events Policies & Guidance About CPP/DCPAS

Home » Our Divisions » Benefits and Work Life Programs » Injury and Unemployment Compensation (ICUC) Branch » Online Tools Overview » DIUCS: Supervisor Link

Print

DIUCS: Supervisor Link

DIUCS is the technical solution that allows Defense Activities to complete CA-1 and CA-2 forms on-line and submit them via the Internet to the Office of Workers Compensation Programs.

Click here for access.

ICUC NAVIGATION

- Injury Compensation
- Unemployment Compensation
- Pipeline
- Training Opportunities
- Online Tools

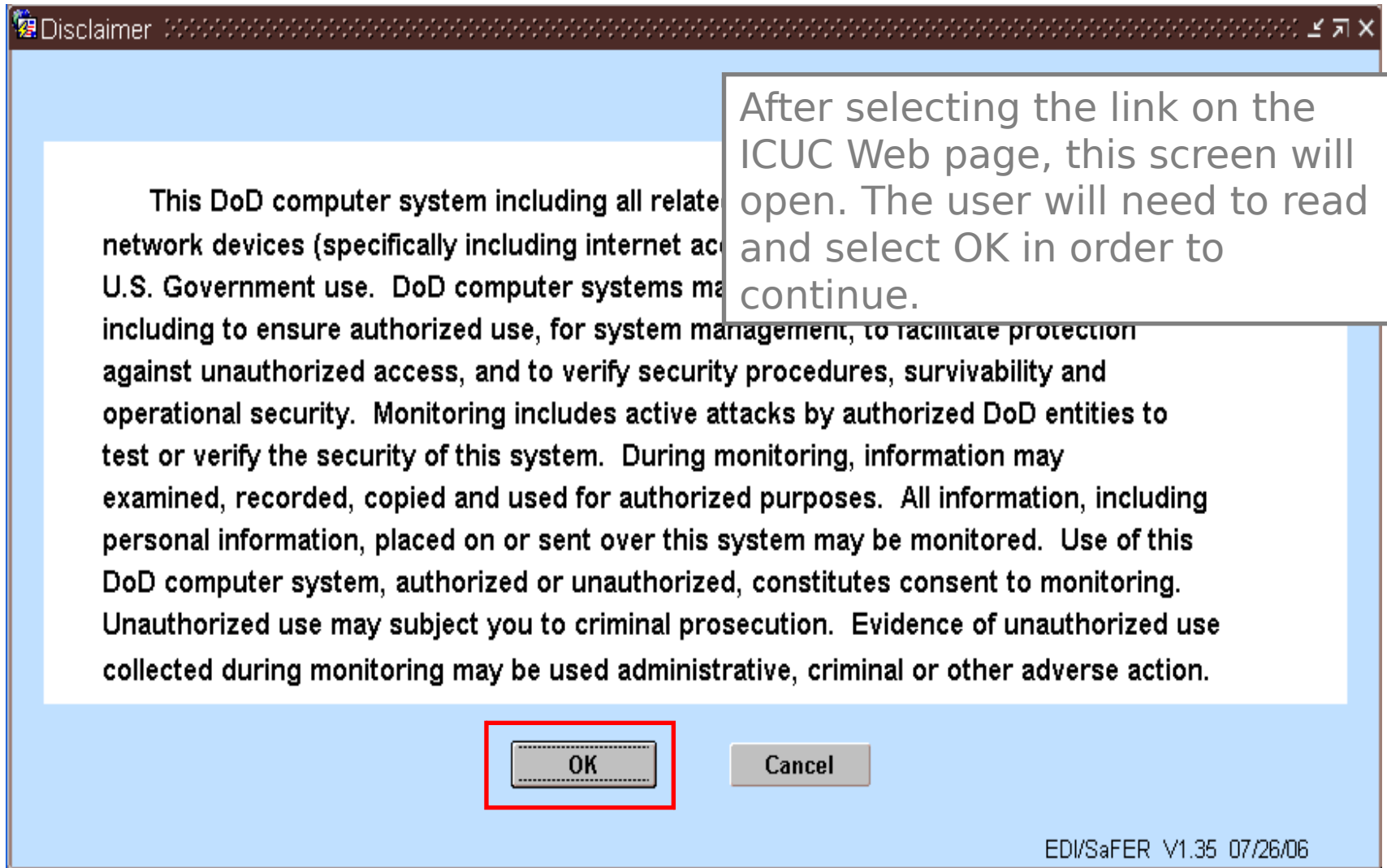
ONLINE TOOLS NAVIGATION

- Overview
- DIUCS Database
- DIUCS System Access & Implementation
- DIUCS Supervisor Link
- DIUCS for ICPAs
- Learning Management System Access & FAQ
- Filing CA-1/CA-2 Online
- Filing CA-3/CA-7 Online
- Request and ICUC Data Report

Trusted sites | Protected Mode: Off

100%

EDI FORM



EDI FORM

Supervisor Entry

Enter A New U.S. Department of Labor Worker's Compensation Claim Form:

Claimant

Social Security Number (SSN):

Date of Birth (MM/DD/YYYY):

Enter employee's SS# without dashes, form will automatically place them for you

Claim Form Type

☒ CA1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

☐ CA2 Notice of Occupational Disease and Claim for Compensation

Choose correct Claim Form Type

Enter claim **Exit**

EDI/SaFER V1.35 07/26/06

EDI FORM

DIUCS v2.1 EDI

Window

Supervisor Entry

ORACLE

**Enter A New U.S. Department of Labor
Worker's Compensation Claim Form:**

Claimant

Social Security Number (SSN): 111-11-1111

Date of Birth (MM/DD/YYYY): 01/01/1960

Claim Form Type

☒ CA-1 Federal Employee's Notice of Traumatic Injury and Claim for Continuation of Pay / Compensation

☐ CA-2 Notice of Occupational Disease and Claim for Compensation

Enter claim

Once the employee's information is added, select the **Enter claim** button to begin entering data.

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: **SMITH** First Name: **JOHN**

Middle Name: **(not entered)** Suffix: **(not entered)**

2. Social Security Number

111-11-1111

3. Date of birth
MM-DD-YYYY
01-01-1960

4. Sex
☒ Male ☐ Female

5. Home Phone

6. Grade as of date of injury
Level: **WG10** Step: **05**

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

☐ Wife, Husband
☐ Children under 18 years
☐ Other

Claim information

EDI claim number: Status:

Trading partner ID: **FECAEDI** Status time:

Record: 1/1

Warning: Applet Window

The form will now open with the employee's information populated into the appropriate fields using data from the personnel system.

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth MM-DD-YYYY

01-01-1960

4. Sex

☒ Male ☐ Female

5. Home Phone

6. Grade as of date of injury

Level: WG10 Step: 05

7. Employee's home mailing address

Street Address:

City:

State: ZIP Code:

8. Dependents

☒ Wife, Husband

☒ Children under 18 years

☒ Other

Claim information

EDI claim number:

Trading partner ID: FE

Record: 1/1

Warning: Applet Window

White fields are required to be filled in.

Yellow fields are optional and do not have to be filled in, with the exception of 8. Dependents

Gray fields are informational and cannot have data entered into them.

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: **SMITH** First Name: **JOHN**

Middle Name: **[Yellow Box]** Suffix: **(not entered)**

2. Social Security Number

111-11-1111

3. Date of birth
MM-DD-YYYY
01-01-1960

4. Sex
☒ Male ☐ Female

5. Home Phone
(123) 455-7890

6. Grade as of date of injury
Level: **WG10** Step: **05**

7. Employee's home mailing address
Street Address: **[Empty Box]**
City: **[Empty Box]**
State: **[Empty Box]** ZIP Code: **[Empty Box]**

8. Dependents
☒ Wife, Husband
☐ Children under 18 years
☐ Other

Claim information
EDI claim number: **[Empty Box]**
Trading partner ID: **FECAEDI**

Some fields require the data entered to be in a particular format. For example, phone numbers should be entered ***without*** using any brackets () or hyphen (-)

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

1. Name of employee

Last Name: **SMITH** First Name: **JOHN**

Middle Name: **[yellow box]** Suffix: **(not entered)**

2. Social Security Number

111-11-1111

3. Date of birth
MM-DD-YYYY
01-01-1960

4. Sex
☒ Male ☐ Female

5. Home Phone
(123) 455-7890

6. Grade as of date of injury
Level: **WG10** Step: **05**

7. Employee's home mailing address

Street Address: **[empty box]**
City: **[empty box]**
State: **[empty box]** ZIP Code: **[empty box]**

8. Dependents

Claim information

EDI claim number: **[empty box]** Status: **[empty box]**
Trading partner ID: **FECAEDI** Status time: **[empty box]**

FRM-40209: Field must be of form FM9999999999999999.
Record: 1/1

Working: Applet Window

If data is entered into a field using the wrong format, the application will not let the user move forward until the data is correctly entered. A message will be provided at the bottom of the screen to inform the user as to what needs to be done to fix the format problem.

EDI FORM

The screenshot displays the 'EDI_CA1' form within the 'DIUCS v2.1 EDI' application. The form is organized into several sections with tabs at the top: 'Emp. Data', 'Injury', 'Emp. Signature', 'Witness', 'Sup Rpt 1', 'Sup Rpt 2', 'Sup Rpt 3', 'Sup Rpt 4', 'Safety Data', and 'Sup Signature'. The 'Emp. Data' tab is active.

1. Name of employee
Last Name: First Name:
Middle Name: Suffix:

2. Social Security Number

3. Date of birth MM-DD-YYYY

4. Sex
☒ Male ☐ Female

5. Home Phone

6. Grade as of date of injury
Level: Step:

7. Employee's home mailing address
Street Address:
City:
State: ZIP Code:

8. Dependents
☐ Wife, Husband
☐ Children under 18 years

Claim information
EDI claim number:
Trading partner ID: Status time:

Footer:
Display List of Corresponding Zip Codes - Press CTRL+L.
Record: 1/1
Warning: Applet window

A blue arrow points from the text box to the ZIP Code field.

A message will also be displayed at the bottom of the screen when a dropdown box is available for a field. Fields with Zip Codes have this function. To activate the box, place the cursor in the field and hold down the CTRL and L keys at the same time.

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1

1. Name of employee

Last Name: SMITH

Middle Name:

Suffix: (not entered)

111-11-1111

3. Date of birth MM-DD-YYYY

01-01-1960

4. Sex

☒ Male ☐ Female

5. Home Phone

6. Grade as of date of injury

Step: 05

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL ZIP Code:

Claim information

EDI claim number:

Trading partner ID: FECAEDI

Listing of Zip Codes

Find FL%

STATE	CITY	ZIP CODE
FL	FLEMING ISLAND	32006
FL	ORANGE PARK	32006
FL	BOSTWICK	32007
FL	BRANFORD	32008
FL	BRYCEVILLE	32009
FL	CALLAHAN	32011
FL	DAY	32013
FL	LAKE CITY	32024
FL	LAKE CITY	32025
FL	FLORIDA DEPT OF CORR	32026

Find OK Cancel

Choices in list: 2629

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

1. Name of employee

Last Name: SMITH First Name: JOHN

Middle Name: Suffix: (not entered)

2. Social Security Number

111-11-1111

3. Date of birth

MM-DD-YYYY

01-01-1960

4. Sex

☒ Male ☐ Female

5. Home Phone

7. Employee's home mailing address

Street Address: 123 MAIN STREET

City: ANYTOWN

State: FL ZIP Code:

Claim information

EDI claim number:

Trading partner ID: FECAEDI

Listing of Zip Codes

Find FL%

STATE	CITY
FL	FLEMING ISLAND
FL	ORANGE PARK
FL	BOSTWICK
FL	BRANFORD
FL	BRYCEVILLE
FL	CALLAHAN
FL	DAY
FL	LAKE CITY
FL	LAKE CITY
FL	FLORIDA DEPT OF CORR

Find OK Cancel

Choices in list: 2629

Record: 1/1

Warning: Applet Window

Entering a state before the % (I.e. FL%) will display all the Zip Codes for that state

Entering a State before the % and city after (I.e. FL%Miami) will display all the Zip Codes for that city.

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)

MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL

FLEMING ISLAND FL

ZIP Code: 32006

10. Date & time injury occurred
MM-DD-YYYY HH:MM [AM|PM]
01-20-2005 02:30 PM

11. Date of this notice
MM-DD-YYYY
01-20-2005

12. Employee's Occupation Description
MAIL CLERK

13. Cause of injury (Describe what happened and why)

I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

a. Occupation code

Cause of injury code

14. Nature of injury (Identify both the injury and the part of body.)

BROKEN NOSE, BRUISED RIBS

Anatomical location code

Part of Body Side of Body

Record: 1/1

Warning: Applet Window

The employee's information will be entered into the system. Pay particular attention to fields that require a date and time such as Block 10. If no time is entered in the block, the time will default to 12:00 am.

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

15. I certify, under penalty of law, that the injury described above was sustained in performance of duty as an employee of the United States Government and that it was not caused by my willful misconduct, intent to injure myself or another person, nor by my intoxication. I hereby claim medical treatment, if needed, and the following, as checked below, while disabled for work:

☒ a. Continuation of regular pay (COP) not to exceed 45 days and compensation for wage loss if disability for work continues beyond 45 days. If my claim is denied, I understand that I may be deemed an overpayment of pay.

☐ b. Sick and/or Annual Leave

☐ c. Unknown

I hereby authorize any physician or hospital (or any other person) to release to the U.S. Department of Labor, Office of Workers' Compensation Programs (or to its official representative), the information requested above. This authorization also permits any official representative of the Office to examine and to copy any records concerning me.

Signature of employee or person acting on his/her behalf _____ Date 01-20-2005

Any person who knowingly makes any false statement, misrepresentation, concealment of fact or any other act of fraud to obtain compensation as provided by the FECA or who knowingly accepts compensation to which that person is not entitled is subject to civil or administrative remedies as well as felony criminal prosecution and may, under appropriate criminal provisions, be punished by a fine or imprisonment or both.

Have your supervisor complete the receipt attached to this form and return it to you for your records.

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. DataInjuryEmp. SignatureWitnessSup Rpt 1Sup Rpt 2Sup Rpt 3Sup Rpt 4Safety DataSup Signature

16. Statement of witness (Describe what you saw, heard, or know about this injury)

Enter a witness statement in this space. The witness will sign the statement when the claim form is printed.
If there is no statement, leave this space blank.
If the statement will not fit into the space annotate "witness statement forwarded under separate cover" in this space and fill out the witness information. Send the separate signed witness statement to the ICPA.

Last NameFirst NameMiddle Name

Name of Witness: .

MM-DD-YYYY

Date signed:

Signature of witness:

Street Address:

City:

State: ZIP Code:

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

17. Agency name and address of reporting office

Agency name: GOVERNMENT AGENCY

Street Address: 123 WORK STREET

City: ANYTOWN

State: FL ZIP Code: 32006

18. Employee's duty station

Street Address: GOVERNMENT AGENCY

City: ANYTOWN

State: FL ZIP Code: 32006

19. Employee's retirement coverage

☐ CSRS ☒ FERS ☐ OTHER (identify)

20. Regular work hours

From: 09:00 AM To: 05:30 PM

21. Regular work schedule

☐ Sun. ☒ Mon. ☒ Tues. ☒ Wed. ☒ Thurs. ☒ Fri. ☐ Sat.

22. Date of injury

MM-DD-YYYY

01-20-2005

23. Date notice received

MM-DD-YYYY

01-20-2005

24. Date & time employee stopped work

MM-DD-YYYY HH:MM [AM|PM]

Warning: Applet Window

Record: 1/1

Enter the required information in the appropriate fields. Paying attention to the format for data entry. (No military time)

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

25. Date pay stopped
MM-DD-YYYY

26. Date 45 day period began
MM-DD-YYYY

27. Date & time employee returned to work
MM-DD-YYYY HH:MM [AM|PM]

28. Was employee injured in performance of duty? —
☒ Yes ☐ No (If "No", explain)

If the supervisor does not believe the employee was injured in performance of duty, "no" should be checked and the facts that support that position should be provided . Otherwise leave the box checked "yes."
If the information will not fit into this box, annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

29. Was injury caused by employee's willful misconduct, intoxication, or intent to injure self or another? —
☐ Yes (If "Yes", explain) ☒ No

If the supervisor believes that willful misconduct was involved, "yes" should be checked and the facts that support this position provided. Otherwise leave the box checked "no"
If the information will not fit into this box annotate "additional information forwarded under separate cover" and send the information to the ICPA to forward to OWCP.

Record: 1/1

Warning: Applet Window

EDI FORM

The screenshot displays the DIUCS v2.1 EDI Oracle application window. The form is titled 'EDI_CA1' and contains several tabs: 'Emp. Data', 'Injury', 'Emp. Signature', 'Witness', 'Sup Rpt 1', 'Sup Rpt 2', 'Sup Rpt 3', 'Sup Rpt 4', 'Safety Data', and 'Sup Signature'. The 'Injury' tab is active.

Block 30: Was injury caused by third party?
☐ Yes
☒ No

Block 31: Name and address of third party (include city, state, and ZIP code)
3rd party name: [Redacted]
name continued: [Redacted]
Street Address: [Redacted]
City: [Redacted]
State: [Redacted] ZIP Code: [Redacted]

Block 32: Name and address of physician first providing medical care (Include city, state, and ZIP code)
Last Name: [Redacted] First Name: [Redacted] Middle Name: [Redacted] Title: [Redacted]
Street Address: [Redacted]
City: [Redacted]
State: [Redacted] ZIP Code: [Redacted]

Block 33: First date medical care received
MM-DD-YYYY
[Redacted]

Block 33a: Provided by Agency medical facility?
☐ Yes ☒ No

Annotations:
- A callout box points to the '33a. Provided by Agency medical facility?' section, stating: 'If the individual was treated at an agency facility the information in Block 32 must be provided (unique to EDI/SAFER)'.
- Another callout box points to the '31. Name and address of third party' section, stating: 'Example of a third party claims would be an automobile accident in which the other driver was found to be at fault.'

Footer:
Record: 1/1
Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness? ☒ Yes ☐ No (If "No", explain)

If, in the investigation of the claim, nothing contradicting the employee or witness is uncovered, it would be appropriate to answer "yes". The supervisor does not have to witness the alleged incident to answer "yes".
If an investigation has been started, but the results are not available at the time of claim filing, then annotate "investigation in progress, results forwarded under separate cover". The ICPA should be provided with a copy of the results to forward to OWCP

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work

Amount: Per:

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 **Sup Rpt 4** Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

☒ Yes ☐ No (If "No", explain)

If the agency wishes to challenge the claim, then "no" must be selected for this item and the reasons for the challenge entered into this space. If the information will not fit, then annotate "additional information will be forwarded under separate cover" and forward the information to the ICPA

36. If the employing agency controverts continuation of pay, state the reason in detail.

37. Pay rate when employee stopped work

Amount: Per: **<not entered>**

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

35. Does your knowledge of the fact about this injury agree with statements of the employee and/or witness?

☒ Yes ☐ No (If "No", explain)

36. If the employing agency controverts continuation of pay, state the reason in detail.

Enter the reason for the controversion of COP in this space.

37. Pay rate when employee stopped work

Amount: Per:

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

Work Environment Exceptions

- ☐ Employee was member of general public
- ☐ Injury resulted from non-work related event
- ☐ Injury resulted from voluntary participation
- ☐ Injury resulted from employee eating, drinking, or smoking
- ☐ Injury resulted from personal grooming
- ☐ Injury resulted from a motor vehicle accident
- ☐ Injury is the common cold or flu.

Privacy Case Status: ☐ A ☐ Not A Privacy Case

General Recording Criteria

- ☐ Employee is deceased as a result of the incident.
- ☐ Employee suffered days away from work as a result of the incident.
- ☐ Employee's work activity was restricted as a result of the incident.
- ☒ Employee was treated in an emergency room as a result of the incident.
- ☐ Employee was hospitalized overnight as an in-patient.
- ☐ Employee lost consciousness as a result of the incident.
- ☐ Employee was transferred to another job as a result of the incident.

Preliminary OSHA Recordability

29 CFR 1960:

OSHA 200 Log Coding:

29 CFR 1904:

OSHA 300 Log Coding:

Injury Classification: ☐ A ☐ Injury

As Of:

Record: 1/1

Warning: Applet Window

Check all that apply for the sections on this tab. This information will be used to generate the OSHA 301 notice used for safety notification (Unique to EDI/SAFER) and will not be sent to OWCP.

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment, effect, etc., in respect of this claim, may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS

If an on-site investigation was performed then a root cause will have to be entered.

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Name of Supervisor: Last Name: SUPERVISOR First Name: JOE Middle Name:

Signature of supervisor: _____ Date signed: MM-DD-YYYY 01-20-2005

Supervisor's Title: SUPERVISOR Supervisor's Email Address: jsupv@govt.mil Supervisor's Office phone number: 1234567890

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical file

☒ No lost time, medical expenses incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

The supervisor's email address should be entered in this field.

View Claim Submit Claim Cancel Exit

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

ORACLE

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Name of Supervisor:

Last Name: SUPERVISOR

First Name: JOE

Middle Name:

Signature of supervisor:

Supervisor's Title: SUPERVISOR

Supervisor's Email Address: jsupv@govt.mil

Date signed: MM-DD-YYYY 01-28-2005

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's file.

☒ No lost time, medical expenses incurred or expected: forward this form to the appropriate agency.

☐ Lost time covered by leave, LWOP, or COP: forward this form to the appropriate agency.

☐ First Aid Injury

Verify the email address

Email Validation

Please re-type your email address here, before you can continue, then press OK.

jsupv@govt.mil

OK

View Claim

Submit Claim

Cancel

Exit

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data Injury Emp. Signature Witness Sup Rpt1 Sup Rpt2 Sup Rpt3 Sup Rpt4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Select the appropriate filing instructions.

Name of Supervisor: Last Name First Name
SUPERVISOR JOE

Signature of supervisor: _____ Date signed: 01-20-2005

Supervisor's Title Supervisor's Email Address: Supervisor's Office phone number
SUPERVISOR jsupv@govt.mil 1234567890

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

☒ No lost time, medical expenses incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

View Claim Submit Claim Cancel Exit

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

ORACLE

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Last Name: SUPERVISOR First Name: JOE Middle Name:

Name of Supervisor: SUPERVISOR, JOE

Signature of supervisor: Date signed: 01-20-2005

Supervisor's Title: SUPERVISOR Supervisor's Email Address: jsupv@govt.mil Supervisor's Office phone number: 1234567890

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical file

☒ No lost time, medical expenses incurred or expected: forward this form to O

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

Select the **View Claim** button

View Claim Submit Claim Cancel Exit

Record: 1/1

Warning: Applet Window

EDI FORM

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data Injury Emp. Signature Witness Sup Rpt 1 Sup Rpt 2 Sup Rpt 3 Sup Rpt 4 Safety Data Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Name of Supervisor: Last Name First Name Middle Name

SUPV MR

Signature of supervisor: Date signed: MM-DD-YYYY

04-13-2006

Supervisor's Title Supervisor's Email Address: Supervisor's Office phone number

SUPERVISOR supv@agency.gov 1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

view Claim Submit Claim Cancel Exit

Record: 1/1

EDI FORM

The screenshot displays the DIUCS v2.1 EDI software interface. The main window has a blue title bar and a menu bar with options like 'Window' and 'ORACLE'. Below the menu bar is a tabbed interface with tabs for 'Emp. Data', 'Injury', 'Emp. Signature', 'Witness', 'Sup Rpt 1', 'Sup Rpt 2', 'Sup Rpt 3', 'Sup Rpt 4', 'Safety Data', and 'Sup Signature'. The 'Sup Signature' tab is currently selected. A large text box is overlaid on the form, providing instructions for the 'View Claim for Printing and Submit to ICPA' and 'View Draft Copy of Claim to Verify Data' options. The form itself contains fields for 'Name of Supervisor' (SUPV), 'MR', 'Signature of supervisor', 'Date signed' (04-13-2006), 'Supervisor's Title' (SUPERVISOR), 'Supervisor's Email Address' (supv@agency.gov), and 'Supervisor's Office phone number' (1234567890). A modal dialog box titled 'Required Submission' is open, asking 'What would you like to do?' and offering two options: 'View Claim for Printing and Submit to ICPA' and 'View Draft Copy of Claim to Verify Data'. The dialog also has 'Cancel' and 'Exit' buttons. The status bar at the bottom shows 'Record: 1/1'.

DIUCS v2.1 EDI

Window

EDI_CA1

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

The ***View Claim for Printing and Submit to ICPA*** option allows the claim to be viewed and printed as a .pdf file and then sent to the ICPA without any further action by the user.

The ***View Draft Copy of Claim to Verify Data*** option allows the claim to be viewed and printed as a .pdf file but the user must then select the **Submit Claim** button to send the claim to the ICPA.

Name of Supervisor: SUPV , MR

Signature of supervisor: _____ Date signed: 04-13-2006

Supervisor's Title: SUPERVISOR Supervisor's Email Address: supv@agency.gov Supervisor's Office phone number: 1234567890

Required Submission

What would you like to do?

View Claim for Printing and Submit to ICPA

View Draft Copy of Claim to Verify Data

Cancel Exit

Record: 1/1

EDI FORM

Acrobat Reader - [rwservlet[2].pdf]

File Edit Document Tools View Window Help

Review the claim. If the information is correct, select the print icon and print the claim. The employee, supervisor, and witness should then sign their portion. The signed copy is forwarded to the ICPA for record retention.

Federal Employee's Notice of Traumatic Injury and Claim for Continuation Pay/Compensation

Employee: Please complete all boxes 1 - 15 below. Do not complete shaded areas.
Witness: Complete bottom section 16.
Employing Agency (Supervisor or Compensation Specialist): Complete shaded boxes a, b, and c.

EDI Tracking Number 100036337

Employee Data

1. Name of Employee (Last, First Middle Suffix) SMITH JOHN			2. Social Security Number 111111111	
3. Date of Birth 01/01/1960	4. Sex MALE	5. Home Telephone 123456789	6. Grade as of date of injury Level WG10 Step 05	
7. Employee's home mailing address (include city, state, and ZIP code) 123 MAIN STREET ANYTOWN FL 32006			8. Dependents <input type="checkbox"/> Wife/Husband <input type="checkbox"/> Children under 18 year <input type="checkbox"/> Other	

Description of Injury

9. Place where injury occurred (e.g. 2nd floor, Main Post Office Bldg., 12th & Pine)
MAIN OFFICE BUILDING, 1223445 WORK STREET, ANYTOWN FL
FLEMING ISLAND FL

10. Date injury occurred 01/20/2005 02:30 PM	11. Date of this notice 01/20/2005	12. Employee's job title MAIL CLERK
---	---------------------------------------	--

13. Cause of injury (Describe what happened and why)
I WAS WALKING DOWN THE STAIRS AND I TRIPPED AND FELL

1 of 8 10 x 11 in

EDI FORM

DIUCS v2.1 EDI

Window

Emp. Data | Injury | Emp. Signature | Witness | Sup Rpt 1 | Sup Rpt 2 | Sup Rpt 3 | Sup Rpt 4 | Safety Data | Sup Signature

38. A supervisor who knowingly certifies to any false statement, misrepresentation, concealment of fact, etc., in respect of this claim may also be subject to appropriate felony criminal prosecution.

I certify that the information given above and that furnished by the employee on the reverse of this form is true to the best of my knowledge with the following exception:

YOU CAN ADD ANY ADDITIONAL INFORMATION IN THIS BLOCK

Was an on-site investigation conducted?

☐ Yes ☒ No

What was the root cause of this injury?

Last Name First Name Middle Name

Name of Supervisor: SUPERVISOR

Signature of supervisor: _____

Supervisor's Title
SUPERVISOR

39. Filing Instructions

☐ No lost time and no medical expense: Place this form in employee's medical folder (SF-66-D)

☒ No lost time, medical expenses incurred or expected: forward this form to OWCP

☐ Lost time covered by leave, LWOP, or COP: forward this form to OWCP

☐ First Aid Injury

View Claim Submit Claim Cancel Exit

FRM-40400: Transaction complete: 1 records applied and saved.
Record: 1/1

Warning: Applet Window

If the **View Draft Copy of Claim to Verify Data** option was selected, the **Submit Claim** button must be selected on order to transmit the claim to the ICPA.

SUMMARY OF SUPERVISOR ACTIONS

- ☐ Supervisor accesses the EDI application through the “Filing Claims Electronically” link on the ICUC Web page.
- ☐ Supervisor enters the SSN and Date of Birth of the employee and selects whether a CA-1 or CA-2 will be filed
- ☐ Employee information is entered onto the form
- ☐ Witness information is entered (if applicable)

SUMMARY OF SUPERVISOR ACTIONS

- ☐ Supervisor enters required information in Supervisors portion of the form
- ☐ The form is printed. The employee, witness and supervisor sign their respective sections.
- ☐ “Submit Claim” button is selected and claim is sent electronically to the ICPA.
- ☐ Signed claim form is sent to the ICPA to be retained in the file